TAC AGENDA – 5-8-2017

- **Call to Order**
- **Addition to previous minutes – motion to accept**

Old Business:

MyNexus With dual eligible patients, Medicaid can come into play if /when The Medicare Advantage plan (MediBlu) does not approve more than a few visits and advise for remaining visits that are ordered/needed they must be through Medicaid. This scenario makes for a complicated issue that also inhibits or can inhibit adequate patient care. This was part of what was explained at the last TAC.

So few visits approved which will impact access to care.
Will MY NEXUS be taking over the prior authorization for Anthem MCO? We have been told from MY NEXUS they will be taking over all prior authorization for all Anthem plans
(Copy of contract supplied)

ORP-Although Mr. Douglass noted that the billing manuals have been updated; agencies still have questions as to where to put the # on the UB. Screen shot as to the location was requested previously and not received.

New Business:

MCO to re-educate staff: Time frame to receive a signed verbal order from a physician in KY. Should be 21 days according to KY regulations to get the signed order. Educate PA staff due to denying Home care status because they are indicating they are not homebound.

MAP 552 and 374 issues Issues with MAP 552 and 374 forms being received. Forms were sent/faxed several times, however they are not showing as received. Currently has 23 patients not showing eligible for hospice) Is there a contact to send the MAP forms to in order for the patients to show eligible for hospice? Is there something to prevent this from happening in the future? *(Due to security need contact to send patients names)*

WellCare: Limits on wound care supplies that are significantly different from the Ky Medicaid supply schedule. They are denying payment and *stating they follow Medicare guidelines*, which seems quite unreasonable since we were told the MCOs would follow MEDICAID guidelines not Medicare. When we ask for a supply schedule from them, they will not give us one. So we have no idea what they will or will not approve until we get a denial and we're being denied for most wound care supplies. *(No samples need contact to send info to)*

WellCare Still having denials with patients that have Medicare and Wellcare. All these Denials are saying " we are unable to provide payment at this time as our records indicate the member has other primary coverage and was submitted without an Explanation of Payment from the prior payer". I have been appealing these denials and sometimes they get paid sometimes they don't. Under the Medicaid contract these claims are required to have a MAP-34 on file and condition code 12 with a date of when

Medicare was not the primary payer on the claim and they get processed. I have also been including this with my appeals and it seems still that it just depends on who gets it to if it gets paid or not. I can give specific examples if you need it. I have sent this into our provider rep several times with no help. *(need specific contact to send samples)*

Humana Caresource say they are faxing the auths back with in a 3 day turn around but I am not getting them and have to call. They have the correct number and after I call I get the fax.

Anthem Medicaid say they are not getting our PA requests (has happened 3 times recently) When they are refaxed with the confirmation it takes another 2-3 day for them to be processed. I think they should be moved to urgent as we have already waited 2-3 day for the auth. It is really hard to call and talk to someone…long waits.

Aetna has told them that MSW evals are not covered (please provide clarification)

MCO issues The issues with **Aetna** are around the timeframe of the Coventry->Aetna transition. All other claims for these patients for supplies have been paid. I have been working with our provider rep on these but still have some claims that I cannot get resolved *(examples below)*

Insurance	Date of Service	Issue
Aetna	10/15/2015	Denied for Medicare--all other claims have paid
Aetna	10/12/2015	Denied for Medicare--all other claims have paid
Aetna	10/1/2015	Denied for Medicare--all other claims have paid
Aetna	12/2/2015	Benefit requires manual review
Aetna	12/2-12/30/2015	Visit denied for no auth-separate authorizations to cover visits
Wellcare	1/25-1/28/2016	Patient's address has changed since we saw him. Claim denied due to address differing from what is on file. Explained that address on claim is correct for the visit in question
Wellcare	6/10-11/14/2016	Claims being rejected before processing electronically. Kicked out of system stating a HIPPS code is needed (T4524)

MWMA: Clarification about documentation in MWMA. Opt out of requirement to also opt out of the MWMA.

Other Business: